ASSEMBLY BILL No. 871

Introduced by Assembly Member Keene

February 18, 2005

An act to amend Sections 4600.3, 4600.5, and 4600.7 of, and to repeal Section 4614 of, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 871, as introduced, Keene. Workers' compensation: health care organizations.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires an employer to provide medical services to an injured worker and permits employers to enter into contracts for the provision of these medical services with a health care organization that has been certified by the administrative director for this purpose.

Existing law relating to services provided by a health care organization provides for the predesignation of a physician by an employee, and requires employers who contract with a health care organization to notify an employee regarding the effect of his or her election to be treated by the health care organization.

This bill would conform these provisions to those applicable to employers who have not entered into a contract with a health care organization for the provision of medical services.

Existing law requires each application for certification as a workers' compensation health care organization to be accompanied by a

reasonable fee, prescribed by the administrative director, sufficient to cover the actual costs of processing the application.

This bill would delete this requirement.

Existing law requires a health care service plan, disability insurer, workers' compensation insurer, third-party administrator, or any other entity determined by the administrative director to have met certain requirements, and that has been deemed to be a workers' compensation health care organization, to report information relating to the effectiveness of the plan to the administrative director.

This bill would make these reporting requirements applicable to the extent the requirements are no more burdensome than the equivalent requirements imposed on medical provider networks or employers or insurers in connection with their use of networks.

Existing law establishes the Workers' Compensation Managed Care Fund containing fees charged to certified health care organizations and applicants for purposes of funding the cost of administration of certification and to repay amounts received as a loan from the General Fund.

This bill would dissolve the fund effective at the end of the fiscal year in which this act is chaptered, eliminate the collection of these fees, waive any remaining balance on the loan, and provide for the return of any balance remaining in the fund to be returned to the General Fund. It also would require that the cost of administration of certification to be borne by the Workers' Compensation Administration Revolving Fund.

Existing law limits the fees that may be paid on a fee-for-service basis to an employee's individual or organizational provider of health care services or to a health care service plan that arranges for health care services under certain circumstances. Existing law requires the administrative director to collect information necessary for the calculation of payments for purposes of these provisions.

This bill would delete these provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 4600.3 of the Labor Code is amended to read:

4600.3. (a) (1) ~~Notwithstanding Section 4600~~ *Subject to subdivision (d) of Section 4600, but notwithstanding subdivision (c) of Section 4600*, when a self-insured employer, group of self-insured employers, or the insurer of an employer contracts with a health care organization certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract~~, providing that the employee may choose to be treated by a personal physician, personal chiropractor, or personal acupuncturist that he or she has designated prior to the injury, in which case the employee shall not be treated by the health care organization. Every employee shall be given an affirmative choice at the time of employment and at least annually thereafter to designate or change the designation of a health care organization or a personal physician, personal chiropractor, or personal acupuncturist. The choice shall be memorialized in writing and maintained in the employee's personnel records. The employee who has designated a personal physician, personal chiropractor, or personal acupuncturist may change their designated caregiver at any time prior to the injury. Any employee who fails to designate a personal physician, personal chiropractor, or personal acupuncturist shall be treated by the health care organization selected by the employer. If the health care organization offered by the employer is the workers' compensation insurer that covers the employee or is an entity that controls or is controlled by that insurer, as defined by Section 1215 of the Insurance Code, this information shall be included in the notice of contract with a health care organization~~.

(2) Each contract described in paragraph (1) shall comply with the certification standards provided in Section 4600.5, and shall provide all medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, that is reasonably required to cure or relieve the effects of the injury, as required by this division, without any payment by the employee of deductibles, copayments, or any share of the premium. However, an employee may receive immediate emergency medical treatment that is compensable from a medical

service or health care provider who is not a member of the health care organization.

(3) Insured employers, a group of self-insured employers, or self-insured employers who contract with a health care organization for medical services shall give notice to employees of eligible medical service providers and any other information regarding the contract and manner of receiving medical services as the administrative director may prescribe. ~~Employees shall be duly notified that if they choose to receive care from the health care organization they must receive treatment for all occupational injuries and illnesses as prescribed by this section.~~

(b) Notwithstanding subdivision (a), no employer which is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law shall contract with a health care organization for purposes of Section 4600.5 with regard to employees whom the bargaining agent is recognized or certified to represent for collective bargaining purposes pursuant to state or federal employer-employee relations law unless authorized to do so by mutual agreement between the bargaining agent and the employer. If the collective bargaining agreement is subject to the National Labor Relations Act, the employer may contract with a health care organization for purposes of Section 4600.5 at any time when the employer and bargaining agent have bargained to impasse to the extent required by federal law.

(c) (1) When an employee is not receiving or is not eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, if 90 days *or more* from the date the injury is reported the employee who has been receiving treatment from a health care organization ~~or his or her physician, chiropractor, acupuncturist, or other agent~~ notifies his or her employer in writing that he or she desires to stop treatment by the health care organization, ~~he or she shall have the right to be treated by a physician, chiropractor, or acupuncturist or at a facility of his or her own choosing within a reasonable geographic area~~ *the selection of physicians to provide all further medical treatment shall be in accordance with subdivision (c) of Section 4600*.

(2) When an employee is receiving or is eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, ~~and has agreed to receive care for occupational injuries and illnesses from a health care organization provided by the employer, the employee may be treated for occupational injuries and diseases by a physician, chiropractor, or acupuncturist of his or her own choice or at a facility of his or her own choice within a reasonable geographic area if the employee or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing only after 180 days from the date the injury was reported, or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported~~ *if 180 days or more from the date the injury is reported the employee who has been receiving treatment from a health care organization notifies his or her employer in writing that he or she desires to stop treatment by the health care organization, the selection of physicians to provide all further medical treatment shall be in accordance with subdivision (c) of Section 4600*.

(3) For purposes of this subdivision, an employer shall be deemed to provide health care coverage for nonoccupational injuries and illnesses if the employer pays more than one-half the costs of the coverage, or if the plan is established pursuant to collective bargaining.

(d) An employee and employer may agree to other forms of therapy pursuant to Section 3209.7.

(e) An employee ~~enrolled in~~ *receiving treatment from* a health care organization shall have the right to no less than one change of physician on request, and shall be given a choice of physicians affiliated with the health care organization. The health care organization shall provide the employee a choice of participating physicians within five days of receiving a request. In addition, the employee shall have the right to a second opinion from a participating physician on a matter pertaining to diagnosis or treatment from a participating physician.

(f) Nothing in this section or Section 4600.5 shall be construed to prohibit a self-insured employer, a group of self-insured employers, or insurer from engaging in any activities permitted by Section 4600.

(g) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization. If the employee does not choose to continue treatment by the health care organization, ~~the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area~~ *the selection of physicians to provide all further medical treatment shall be in accordance with subdivision (c) of Section 4600*.

SEC. 2. Section 4600.5 of the Labor Code is amended to read:

4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article.

(b) ~~Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application.~~ A certificate is valid for the period that the director may prescribe unless sooner revoked or suspended.

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, and has provided the Managed Care Unit of the Division of Workers' Compensation with the necessary documentation to comply with this subdivision, that organization shall be deemed to be a health care organization able to provide health care pursuant to Section 4600.3, without further application duplicating the documentation already filed with the Department of Managed Health Care. These plans shall be required to remain in good standing with the Department of Managed Health Care, and shall meet the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan*, provided that the reporting requirements shall be no more burdensome than the equivalent requirements imposed on medical provider networks or employers or insurers in connection with their use of medical provider networks established pursuant to Section 4616*.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Managed Health Care in compliance with the Knox-Keene Health Care Service Plan Act, relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees in compliance with the requirements of this code.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1 of the Health and Safety Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance

with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Insurance and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan*, provided that the reporting requirements shall be no more burdensome than the equivalent requirements imposed on medical provider networks or employers or insurers in connection with their use of medical provider networks established pursuant to Section 4616*.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Insurance in compliance with the Insurance Code relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of Section 4600.6, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that it meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan*, provided that the reporting requirements shall be no more burdensome than the equivalent requirements imposed on medical provider networks or employers or insurers in connection with their use of medical provider networks established pursuant to Section 4616*.

(4) Agrees to provide the administrative director with information, reports, and records relating to provider accessibility, peer review, utilization review, quality assurance, advertising, disclosure, medical and financial audits, and grievance systems, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential

communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(7) Complies with the following requirements:

(A) An organization certified by the administrative director under this subdivision may not provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost of that health care in return for a prepaid or periodic charge paid by or on behalf of those employees.

(B) Every organization certified under this subdivision shall operate on a fee-for-service basis. As used in this section, fee for service refers to the situation where the amount of reimbursement paid by the employer to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.

(C) An organization certified under this subdivision is prohibited from assuming risk.

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

(2) An entity that had, on December 31, 1997, submitted an application with the Commissioner of Corporations under Part 3.2 (commencing with Section 5150) shall be considered an applicant for certification under subdivision (e) and shall be entitled to priority in consideration of its application. The Commissioner of Corporations shall provide complete files for all pending applications to the administrative director on or before January 31, 1998.

(g) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(h) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a

per-enrollee-periodic-charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(i) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(j) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(k) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Health Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(*l*) (1) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a chiropractor, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated chiropractor for work-related injuries that are within the guidelines for chiropractic care established by paragraph (2). Chiropractic care rendered in accordance with guidelines for chiropractic care established pursuant to paragraph (2) shall be provided by duly licensed chiropractors affiliated with the plan.

(2) The health care organization shall establish guidelines for chiropractic care in consultation with affiliated chiropractors who are participants in the health care organization's utilization

review process for chiropractic care, which may include qualified medical evaluators knowledgeable in the treatment of chiropractic conditions. The guidelines for chiropractic care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated chiropractor for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of chiropractic care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for chiropractic care in accordance with the health care organization's guidelines for chiropractic care established by paragraph (2).

Chiropractic utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for chiropractic care. Chiropractors affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of chiropractic care for work-related injuries, the review shall include review by a chiropractor affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to chiropractic care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for chiropractic care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

(m) Individually identifiable medical information on patients submitted to the division shall not be subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(n) (1) When an injured employee requests acupuncture treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist pursuant to guidelines for acupuncture care established by paragraph (2). Within five working days of the employee's request to see an acupuncturist, the health care organization and any person or entity who directs the kind or

manner of health care services for the plan shall refer an injured employee to an affiliated acupuncturist for work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.

(2) The health care organization shall establish guidelines for acupuncture care in consultation with affiliated acupuncturists who are participants in the health care organization's utilization review process for acupuncture care, which may include qualified medical evaluators. The guidelines for acupuncture care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated acupuncturist for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of acupuncture care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for acupuncture care in accordance with the health care organization's guidelines for acupuncture care established by paragraph (2).

Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to acupuncture care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for acupuncture care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

SEC. 3. Section 4600.7 of the Labor Code is amended to read:

4600.7. ~~(a)~~ The Workers' Compensation Managed Care Fund is hereby ~~created in the State Treasury for the administration of Sections 4600.3 and 4600.5 by the Division of Workers' Compensation~~ *dissolved effective at the end of the fiscal year in which the bill dissolving the fund is enacted*. ~~The administrative director shall establish a schedule of fees and revenues to~~ *No fees shall* be charged to certified health care organizations and applicants for certification to ~~fully~~ fund the administration of these provisions and to repay amounts received as a loan from the General Fund *after the date the bill dissolving the Workers' Compensation Managed Care Fund is enacted*. All fees and revenues ~~shall be~~ deposited in the Workers' Compensation Managed Care Fund ~~and~~ shall be used when appropriated by the Legislature solely for the purpose of carrying out the responsibilities of the ~~Division of Workers' Compensation~~ *division* under Section 4600.3 or 4600.5*, and any balance remaining in the fund on the date the fund is dissolved shall be returned to the General Fund. Any remaining balance on the loan from the General Fund shall be waived. Commencing with the beginning of the fiscal year following the date the bill dissolving the Workers' Compensation Managed Care Fund is enacted, the cost of administration of Sections 4600.3 and 4600.5 by the division shall be borne by the Workers' Compensation Administration Revolving Fund established by Section 62.5*.

~~(b) On and after July 1, 1998, no funds received as a loan from the General Fund shall be used to support the administration of Sections 4600.3 and 4600.5. The loan amount shall be repaid to the General Fund by assessing a surcharge on the enrollment fee for each of the next five fiscal years. In the event the surcharge does not produce sufficient revenue over this period, the surcharge shall be adjusted to fully repay the loan over the following three fiscal years, with the final assessment calculated by dividing the balance of the loan by the enrollees at the end of the final fiscal year.~~

SEC. 4. Section 4614 of the Labor Code is repealed.

~~4614. (a) (1) Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with the employee's health benefit program, and~~

~~the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.~~

~~(2) A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider for nonoccupational injuries and illnesses, with the exception of a nonprofit health care service plan that exclusively contracts with a medical group to provide or arrange for medical services to its enrollees in a designated geographic area, shall be paid by the employer for services rendered under this division only on a capitated basis.~~

~~(b) (1) Where the employee's individual or organizational provider of health care services rendered under this division who is not providing services under a contract is not the provider of health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is no more than the average of the payment that would have been paid by five of the largest preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.~~

~~(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.~~

~~(c) Nothing in this section shall prohibit an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an~~

~~employer, insurance carrier, third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that the administrative director has determined that the alternative negotiated rates between the organizational or individual provider and a payer, a third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on billings were to be charged at the scheduled rate.~~

~~(d) For the purposes of this section, "organizational provider" means an entity that arranges for health care services to be rendered directly by individual caregivers. An organizational provider may be a health care service plan, disability insurer, health care organization, preferred provider organization, or workers' compensation insurer arranging for care through a managed care network or on a fee-for-service basis. An individual provider is either an individual or institution that provides care directly to the injured worker.~~

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